Georgetown University Hospital

MedStar Health

DIVISION OF THORACIC SURGERY HEALTH HISTORY

To be completed by the patient

PATIENT NAME			DATE COMPLETED
DATE OF BIRTH	SEX	HEIGHT	WEIGHT
DAY PHONE		EVENING PHONE	
FAMILY DOCTOR			PHONE
OTHER DOCTOR	SPECIALTY		PHONE
OTHER DOCTOR	SPECIALTY		PHONE

A. To your knowledge, do you have or have you ever had any of the following complications:

RESPIRATORY	YES	NO
Recent cold, Bronchitis or Pneumonia	❑	❑
History of Asthma or Wheezing	❑	❑
Tuberculosis or Silicosis	❑	❑
Sleep Apnea / Excessive Snoring	❑	❑
Shortness of Breath at Rest	❑	❑
Shortness of Breath with Limited Exercise or at Night	❑	❑
Chronic Cough or Lung Problems	❑	❑
HEMATOLOGIC	**YES**	**NO**
History of Anemia (low blood count)	❑	❑
Sickle-cell Anemia / Trait	❑	❑
History of Bleeding or Bruising	❑	❑
Blood Transfusion	❑	❑
Phlebitis / Blood Clots	❑	❑
CARDIOVASCULAR	**YES**	**NO**
Irregular Heart Beat	❑	❑
Mitral Valve Prolapse	❑	❑
Heart Murmur	❑	❑
Rheumatic Fever	❑	❑
High Blood Pressure	❑	❑
Heart Attack	❑	❑
Heart Failure	❑	❑
Chest Discomfort or Tightness (Angina)	❑	❑
Poor circulation to Feet / Legs	❑	❑

GASTROINTESTINAL	YES	NO
Liver disease / Jaundice / Hepatitis	❑	❑
Chronic Heartburn	❑	❑
Hiatal Hernia	❑	❑
NEUROLOGIC	**YES**	**NO**
Stroke / TIA / Mini-stroke	❑	❑
Multiple Sclerosis or Polio	❑	❑
Weakness or Paralysis (Temporary or Perm.)	❑	❑
Head injury	❑	❑
Epilepsy / Seizures	❑	❑
ENDOCRINE	**YES**	**NO**
Thyroid Disorder	❑	❑
Diabetes	❑	❑
OTHER PROBLEMS	**YES**	**NO**
Chronic Back Problems	❑	❑
Loose or Chipped Teeth Presently	❑	❑
Temporal Mandibular Joint Disease	❑	❑
Scoliosis	❑	❑

OTHER:

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B. Have you ever had any of the following:

	YES	NO	If you answer "YES" to any of these, please provide the location and year completed.	
Exam by a cardiologist	❑	❑	Location ______	Year ______
Electrocardiogram (EKG)	❑	❑	Location ______	Year ______
Heart Catheterization	❑	❑	Location ______	Year ______
Thallium Stress Test	❑	❑	Location ______	Year ______
Ultrasound of Heart	❑	❑	Location ______	Year ______
Pacemaker	❑	❑	Location ______	Year ______
Anesthesia	❑	❑	Location ______	Year ______
Pulmonary Function Test	❑	❑	Location ______	Year ______
Exam by a pulmonologist	❑	❑	Location ______	Year ______
Chest XRAY or CT Scan	❑	❑	Location ______	Year ______

PLEASE TURN TO THE NEXT PAGE AND CONTINUE

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Patient Name ____________________

DOB ____________________

MRN ____________________

C. Are you allergic to any of the following:

	YES	NO	Please list all allergies and the reaction that they cause.
Any Medications	❑	❑	
Adhesive Tape	❑	❑	
Any Food	❑	❑	
Iodine on your skin	❑	❑	
IV dye	❑	❑	
Latex	❑	❑	

D. Please list any active medical problems which you have. Please attach additional pages if necessary.

____

____

____

____

E. Please list all medications you are presently taking. Include the dosage and the frequency.
Please include non-prescription medications, such as iron, aspirin, antacids, laxatives and all herbal or natural supplements. Attach additional pages if necessary.

F. Have you taken any Aspirin or Aspirin-like products (Motrin, Advil, Nuprin) in the last 10 days? ❑ **YES** ❑ **NO**
If yes, please list the medications you have taken.

____

____

G. Previous Hospitalizations
Please list all previous hospitalizations (surgery, childbirth, procedures, medical illness). Attach additional pages if necessary.

DATE (Approximate Year)	REASON	PLACE (Hospital Name and/or City)

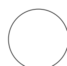
H. If you are scheduled for surgery or a hospital stay, please complete the following questions? ❑ **YES** ❑ **NO**
(Otherwise, please skip to the next section):

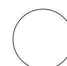
1. Do you have religious or moral objections to medically necessary blood transfusions? ❑ YES ❑ NO

   a. If yes, please describe: ____________________

2. Do you have any other special concerns? ____________________

PLEASE TURN TO THE NEXT PAGE AND CONTINUE





DIVISION OF THORACIC SURGERY HEALTH HISTORY

To be completed by the patient

Patient Name ____________________

DOB ____________________

MRN ____________________

I. *Social History and Psychosocial Screening*

We request the following information to facilitate your care or provide resource information regarding available services. If you are offended by the personal nature of the question content, do not answer the question.

PSYCHOSOCIAL YES NO

Marital Status: ____________________

Occupation: ____________________

Retired? . . . . ❑ ❑

Have you ever been exposed to toxic or non-toxic substances? . . . . ❑ ❑

Have you traveled abroad? . . . . ❑ ❑

If yes, where to? ____________________

Have you been exposed to communicable diseases? . ❑ ❑

Do you, or have you ever smoked? . . . . ❑ ❑

Number of pack / cigars a day? ____________________

Number of years? ____________________

Do you drink alcoholic beverages? . . . . ❑ ❑

If yes, on average, how many drinks per week? ____________

Do you use recreational drugs? . . . . ❑ ❑

Women only: Are you pregnant? . . . . ❑ ❑

Date of last menstrual period: ____________________

Number of pregnancies: ____________________

Number of Children: ____________________

NUTRITIONAL ASSESSMENT YES NO

Have you had any unintentional weight loss of more than ten pounds over the last 3 months? . . . . ❑ ❑

Have you had persistent vomiting or diarrhea lasting 3 days or more? . . . . ❑ ❑

Have you experienced loss of appetite lasting more than five days? . . . . ❑ ❑

Do you have difficulty swallowing? . . . . ❑ ❑

Do you have difficulty obtaining adequate food? . . . . . . ❑ ❑

Do you have any ethnic/cultural dietary preferences? . ❑ ❑

If "YES" please describe your dietary preferences:

____

____

FUNCTIONAL YES NO

Activities of daily living. Do you have difficulty with the following:

Grooming / Dressing? . . . . ❑ ❑

Bathing? . . . . ❑ ❑

Feeding yourself? . . . . ❑ ❑

Walking? . . . . ❑ ❑

Have you had a fall recently? . . . . ❑ ❑

Do you use a cane, crutches, walker or wheelchair? . . ❑ ❑

Are you able to walk: *(please check answer)*

❑ 1 block ❑ 2 block ❑ more than 2 blocks

Stairs: ❑ 1 flight ❑ 2 flights ❑ other ____________

Has your ability to do any of the functional activities listed above recently changed? . . . . ❑ ❑

Do you wear: *(please check answer)*

❑ Glasses ❑ Contacts ❑ Hearing Aid ❑ Dentures

Are you hearing impaired? . . . . ❑ ❑

PAIN ASSESSMENT YES NO

Do you currently have any pain? . . . . ❑ ❑

If yes:

1. Where is the location of the pain? ____________________
2. Rate the severity of pain: (0 = no pain, 10 = severe pain)

   ____
3. How long have you had this pain? ____________________
4. What relieves your pain? ____________________

   ____

PLEASE TURN TO THE NEXT PAGE AND CONTINUE

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J. Family History:

Please note if they are living or deceased			If deceased, age at death	Health conditions, including cause of death, if applicable
Mother:	❑ Living	❑ Deceased	________	______________________
Father:	❑ Living	❑ Deceased	________	______________________
Maternal Grandmother:	❑ Living	❑ Deceased	________	______________________
Maternal Grandfather:	❑ Living	❑ Deceased	________	______________________
Paternal Grandmother:	❑ Living	❑ Deceased	________	______________________
Paternal Grandfather:	❑ Living	❑ Deceased	________	______________________
Sibling:	❑ Living	❑ Deceased	________	______________________
Other: ______________			________	______________________
Other: ______________			________	______________________
Other: ______________			________	______________________

Have any of your blood relatives had any of the following:

	YES	NO	Relationship to Family Member
Diabetes requiring insulin	❑	❑	______________________
Heart attack or severe heart disease	❑	❑	______________________
Problems with anesthesia	❑	❑	______________________
Lung problems	❑	❑	______________________
Cancer	❑	❑	______________________
TYPE: ______________			
Cancer	❑	❑	______________________
TYPE: ______________			

Patient Signature	Date

FOR CLINIC USE ONLY. PATIENT IS NOT TO COMPLETE:

Reviewed By:	Date